

**Child and Adult Care Food Program Survey
for Child Care Centers**

Please complete the following concerning your child and return immediately in the envelope provided.

1. **Child's Name:** _____

2. **Child Care Facility Name:** _____

3. **Date of Enrollment at child care (first day attended this facility):** _____

4. **Child's Birth Date:** _____

5. **Check the box next to the days of the week your child is in care at this facility:**

- | | | |
|----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sunday | <input type="checkbox"/> Wednesday | <input type="checkbox"/> Saturday |
| <input type="checkbox"/> Monday | <input type="checkbox"/> Thursday | |
| <input type="checkbox"/> Tuesday | <input type="checkbox"/> Friday | |

6. **Normal hours of care** (time child arrives at child care and time child is picked up):

Dropped off: _____ Picked up: _____

7. **Check the box next to the meals you expect your child to receive while in child care:**

- | | | |
|--|--|--|
| <input type="checkbox"/> Breakfast | <input type="checkbox"/> Lunch | <input type="checkbox"/> Evening Snack |
| <input type="checkbox"/> Morning Snack | <input type="checkbox"/> Afternoon Snack | <input type="checkbox"/> Supper |

8. **Is your child in care?** (check the appropriate box)

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> All day | <input type="checkbox"/> Before School | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Half Day Morning | <input type="checkbox"/> After School | <input type="checkbox"/> Overnight |
| <input type="checkbox"/> Half Day Afternoon | <input type="checkbox"/> Before and After | |

School

Parent's signature

Date

Optional information:

Phone number: _____

May we contact you for additional information if necessary? Yes No

Thank you for your time and assistance.

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